

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2011
NAME OF PROVIDER OR SUPPLIER NEWPORT HEALTH AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 135 GENERATION DRIVE NEWPORT, TN 37821		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on June 13, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1